IN THE SUPREME COURT OF THE STATE OF HAWAIʻI

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ALOHACARE, Petitioner/Appellant-Appellant,

vs.

GORDON I. ITO, INSURANCE COMMISSIONER, STATE OF HAWAIʻI DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS, Respondent/Appellee-Appellee,

and

UNITED HEALTHCARE INSURANCE COMPANY dba EVERCARE; WELLCARE HEALTH INSURANCE OF ARIZONA, INC., dba OHANA HEALTH PLAN AND AFFILIATES; and DEPARTMENT OF HUMAN SERVICES, STATE OF HAWAIʻI, Respondents/Intervenors-Appellees-Appellees.

NO. SCAP-30276

APPEAL FROM THE CIRCUIT COURT OF THE FIRST CIRCUIT
(ICA NO. 30276; CIV NO. 09-1-1514)

JANUARY 25, 2012

RECKTENWALD, C.J., DUFFY, J., CIRCUIT JUDGE NISHIMURA, ASSIGNED IN PLACE OF NAKAYAMA, J., RECUSED, AND CIRCUIT JUDGE LEE, ASSIGNED BY REASON OF VACANCY, WITH ACOBA, J., CONCURRING AND DISSENTING SEPARATELY

OPINION OF THE COURT BY RECKTENWALD, C.J.

AlohaCare, a health maintenance organization, submitted a proposal to the Department of Human Services to bid for a Quest

Expanded Access contract to provide healthcare services for aged, blind, or disabled participants in the State's Medicaid program. AlohaCare was not one of the successful bidders. The Department of Human Services instead awarded Quest Expanded Access contracts to United HealthCare Insurance Company, dba Evercare (United), and WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan (Ohana).

AlohaCare petitioned the Insurance Commissioner of the Department of Commerce and Consumer Affairs for declaratory relief that accident and health insurers like United and Ohana were not properly licensed to carry out the activities called for under the Quest Expanded Access contracts and that a health maintenance organization license issued pursuant to the Health Maintenance Organization Act, Hawaiʻi Revised Statutes chapter 432D, quoted infra, was instead required. The Insurance Commissioner concluded that a health maintenance organization license was not required to offer the Quest Expanded Access managed care product because the services required under the contracts were not services that can be provided only by a health maintenance organization. On appeal to the circuit court, AlohaCare argued that the Insurance Commissioner's Decision was wrong, and, in effect, nullified the Health Maintenance Organization Act. The circuit court upheld the Decision of the Insurance Commissioner. On appeal, AlohaCare challenges the circuit court's judgment in favor of United, Ohana, the

Department of Human Services and the Insurance Commissioner.

As set forth below, we hold that AlohaCare has standing to appeal the Insurance Commissioner's Decision. We further hold that both accident and health insurers and health maintenance organizations are authorized to offer the closed panel or limited physician group model of care required by the Quest Expanded Access contracts. We conclude that this holding does not nullify the Health Maintenance Organization Act. Accordingly, we affirm the circuit court's judgment.

I. BACKGROUND

The following facts are taken from the agency record on appeal, the circuit court record on appeal, including transcripts of the proceedings before the circuit court, and the Insurance Commissioner's unchallenged findings of fact.

A. The QExA Request for Proposals

On October 10, 2007, the Department of Human Services (DHS) issued Request for Proposals (RFP) No. RFP-MQD-2008-006 "QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind, or Disabled." The RFP provided, in part:

> This [RFP] solicits participation by qualified and properly licensed health plans to provide required service coordination, outreach, improved access, and enhanced quality healthcare services through a managed care system for the State's Medicaid aged, blind or disabled (ABD) members who are currently not covered through a managed care system across the continuum of care. The services shall be provided in a managed care environment with reimbursement to qualifying health plans based on fully capitated rates for each island.

(Emphasis added).

The RFP defined "managed care" as "[a] comprehensive approach to the provision of healthcare that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost-effective manner." The RFP further provided that "QExA is a managed care program and, as such, all acute, pharmacy and long-term care services to members shall be provided in a managed care system."

Regarding licensure, the RFP provided that:

> The health plan shall be properly licensed as a health plan in the State of Hawaii (See [Hawaiʻi Revised Statutes (HRS) chapters 431, and 432, and 432D]). The health plan need not be licensed as a federally qualified HMO, but shall meet the requirements of Section 1903(m) of the Social Security Act [(42 U.S.C. § 1396(m))] and the requirements specified by the DHS.

(Emphasis added).

The RFP's definition of "Health Maintenance Organization (HMO)" referred to its definition of "Managed Care Organization," which stated:

> An entity that has, or is seeking to qualify for, a comprehensive risk contract under the final rule of the [federal Balanced Budget Act of 1997] and that is: (1) a federally qualified HMO that meets the requirements under Section 1310(d) of the Public Health Service Act; (2) any public or private entity that meets the advance directives requirements and meets the following conditions: (a) makes the service it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services that are available to other Medicaid enrollees within the area served by the entity and (b) meets the solvency standards of 42 CFR Section 438.116 and HRS § 432-D-8 [sic].

The RFP also defined the term "Participating" as

> [w]hen referring to a provider, a healthcare provider who is employed by or who has entered into a contract with the health plan to provide covered services to members. When referring to a facility, a facility which is owned and operated by, or which has entered into a contract with the health plan for the provision of covered services to members.

The RFP required that successful bidders "develop and maintain a provider network that is sufficient to ensure that all medically necessary covered services are accessible and available" to plan members. To that end, the RFP set forth the minimum size of the plan's provider network, including the number of primary care physicians, specialists and hospitals required on each island. Under the QExA RFP, if the health plan is unable to provide medically necessary covered services to a member within its network or on the island of residence, then the health plan must provide the services out-of-network or transport the member to another island to access the services.

No party disputes that the QExA RFP contemplated the provision of a "closed panel" plan, "meaning that care must be obtained from the contracted network of providers if it is available within the network."

B. AlohaCare, United, and Ohana's eligibility to offer the product required by the QExA RFP

AlohaCare alleges, and the other parties do not dispute, that AlohaCare is licensed as a health maintenance organization under HRS chapter 432D.[1] United and Ohana are

[1] HRS § 432D-1 defines a "[h]ealth maintenance organization" as "any person that undertakes to provide or arrange for the delivery of basic (continued...)

licensed as accident and health insurers under HRS chapter 431:10A, quoted infra. It is undisputed that United and Ohana are not licensed as health maintenance organizations under HRS chapter 432D.

On October 30, 2007, prior to submitting its application in response to the RFP, United inquired by letter to the Insurance Division as to whether United would be able to offer the closed panel managed care product called for under the RFP pursuant to its accident and health insurer license. The Health Branch Administrator at the Insurance Division responded to United by letter on November 1, 2007, stating that the plain text of HRS § 431:10A-205(b) would not allow United to offer a "closed panel or limited physician group HMO model of care."[2]

United replied by letter on November 12, 2007 providing additional information and requesting a clarification of the Health Branch Administrator's letter. On November 13, 2007, after conferring with the Insurance Commissioner, the Insurance

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[1](...continued)
health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments, deductibles, or both." (Emphasis added).

[2] HRS § 431:10A-205(b) (2005) provides:

> Any group or blanket disability policy may provide that all or any portion of any indemnities provided by the policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount so paid.

(Emphasis added).

Division reversed its interpretation of HRS § 431:10A-205(b), stating that "our interpretation is that the referenced statute does not prohibit offering a closed panel HMO product for Medicaid-Quest under the accident and health license." (Emphasis in original). On November 16, 2007, the Insurance Division communicated by letter to United that its "[r]esponse in the November 13, 2007 letter is based upon the information and/or documentation provided by [United] and is informational in nature." On April 24, 2008, the Health Branch Administrator provided a similar opinion to Ohana.[3]

On February 1, 2008, DHS awarded the QExA contracts to United and Ohana. That same day, DHS sent AlohaCare a letter informing AlohaCare that it was not chosen by DHS as one of the health plans selected to provide the services in the QExA RFP. The letter informed AlohaCare that the two health plans chosen for the contract were Ohana and United. The letter also informed

[3] The April 24, 2008 letter stated, in pertinent part:

> Insurance Commissioner J.P. Schmidt has taken the position that an accident and health or sickness insurer under HRS article 431:10A or a mutual benefit society under HRS chapter 432 can write an HMO product. Therefore, it is our position that [Ohana] could write QUEST HMO product business under its existing license. . . .
>
> The matter is not free from doubt, however, due to language contained in HRS Section 431:10A-205(b) and HRS section 432D-2(a). We think there are good arguments that the language in these sections does not prohibit the writing of an HMO product under another type of license. That said, you should undertake your own evaluation of the issues and risks.

AlohaCare that DHS was

> returning your business proposal(s) which [were] unopened. Unfortunately, your proposal did not meet the technical requirements necessary to forward the business proposal on for review by our actuaries. Enclosed are a copy of your proposal evaluation worksheet for your technical proposal and a copy of the Consensus Score Sheets used in the technical proposal review.

On February 4, 2008, the contracts were executed.[4]

C. Proceedings before the Insurance Commissioner

On October 28, 2008, AlohaCare filed its Petition for Hearing and Declaratory Relief with the Insurance Commissioner of the DCCA. AlohaCare asserted that it was both an "interested party" and an "aggrieved person."[5] The Petition named Jeffrey P.

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[4] AlohaCare subsequently challenged the contracts in a variety of ways. On February 22, 2008, AlohaCare filed a protest of the QExA contract awards with the DHS Director pursuant to HRS § 103F-501(b) (Supp. 2008), arguing, inter alia, that United and Ohana were ineligible for the QExA contracts on various grounds. This protest did not raise improper licensure as a ground. The DHS Director upheld the procurement award. AlohaCare moved for reconsideration pursuant to HRS § 103F-502(c) (Supp. 2008) and the Chief Procurement Officer upheld the procurement award. AlohaCare appealed to the Department of Commerce and Consumer Affairs (DCCA) for administrative review, and the DCCA dismissed the appeal for lack of jurisdiction. AlohaCare appealed the dismissal to the circuit court. The circuit court upheld the dismissal, and the ICA affirmed. AlohaCare v. Dep't of Human Servs., No. 29630, 2011 WL 3250430 (Haw. App. July 28, 2011). AlohaCare subsequently filed an application for a writ of certiorari, which this court accepted on December 12, 2011.

Additionally, on May 8, 2008, AlohaCare filed suit in the United States District Court for the District of Hawaiʻi (district court) alleging violations of federal law and the United States Constitution. The district court dismissed the action, AlohaCare v. Dep't of Human Servs., 567 F. Supp. 2d 1238, 1265 (D. Haw. 2008), and the Ninth Circuit Court of Appeals upheld the dismissal, AlohaCare v. Dep't of Human Servs., 572 F.3d 740, 747 (9th Cir. 2009).

[5] "[A]ny interested person may petition [any authority of the DCCA] for a declaratory ruling as to the applicability of any statutory provision or of any rule or order adopted by the authority to a factual situation." Hawaiʻi Administrative Rules (HAR) § 16-201-48 (1990) (emphasis added); see also HRS § 91-8 (1993).

"[A]ny aggrieved person may petition the authority or hearings officer for a hearing to resolve a contested matter, including license denials, within the authority's jurisdiction." HAR § 16-201-26 (1990) (emphasis added).

(continued...)

Schmidt, Insurance Commissioner, as the sole respondent. AlohaCare sought, inter alia, an "official determination" that Ohana "is not licensed pursuant to the HMO Act and is therefore not properly licensed to perform the QExA [c]ontract."[6]

In AlohaCare's memorandum accompanying its Petition, AlohaCare argued, inter alia, "that the work to be conducted under the [QExA] contract is covered only by Hawaii's [HMO] statute and therefore can legally be performed only by entities that hold Hawaii HMO licenses." In support of that proposition, AlohaCare argued that the QExA RFP involved the performance of "HMO activities" and that "any entity performing HMO activities as described in the HMO Act must have an HMO license."[7] (Emphasis in original).

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[5](...continued)
HAR § 16-201-2 (1990) defines "aggrieved person," as used in HAR chapter 201, as:

> any person who shall be adversely affected by an action, decision, order or rule of the authority or who shall be adversely affected by the action or conduct of any person if the action or conduct is within the authority's jurisdiction to regulate, and shall also include any person who requires the authority's permission to engage in or refrain from engaging in an activity or conduct which is subject to regulation by the authority.

[6] AlohaCare did not make any explicit allegations concerning United in either the Petition or AlohaCare's memorandum accompanying the Petition. However, AlohaCare's contention that an HMO license was required under Hawaiʻi law to perform the QExA contract would apply equally to Ohana and United, which are both licensed as accident and health insurers under HRS chapter 431:10A.

[7] Although AlohaCare's Petition raised additional arguments regarding the validity of the contracts, the Insurance Commissioner did not address these arguments, and they are not at issue in this appeal. Accordingly, these arguments are not discussed further.

On December 8, 2008, DHS, which had not yet intervened in the proceeding,[8] filed an Amended Motion to Dismiss the Petition in which United and Ohana joined. DHS argued that DHS "does not believe that its contracts with Ohana and [United] are contracts relating to the business of insurance[,]" and therefore, DHS argued, the Insurance Commissioner "does not possess the power" to provide the relief AlohaCare requests because it would exceed the statutory authority of the Insurance Commissioner. The Insurance Commissioner denied the motion.

United subsequently filed its memorandum in opposition to the Petition, in which it contended that federal law did not require Medicaid managed care organizations to be licensed as HMOs. United further argued that Hawaiʻi law does not require an HMO license to provide the QExA product because United's "provision of the QExA product is not precluded by HRS § 431:10A-205(b)" and "the QExA program is 'managed care,' not an 'HMO activity.'" (Formatting altered).

Ohana filed a memorandum in opposition to the Petition in which it argued, inter alia, that Hawaiʻi law permits Ohana to provide the services under the QExA contract because the HMO Act does not require Ohana to possess an HMO license to perform such services. Accordingly, Ohana argued that it was permitted under

[8] On January 7, 2009, the Insurance Commissioner entered orders granting motions to intervene filed by DHS, United and Ohana. On January 9, 2009, the Insurance Commissioner entered an amended order granting United's motion to intervene that did not substantively affect the prior order.

its accident and health insurance license to provide the services under the QExA contract. Ohana also argued that the Insurance Commissioner lacked jurisdiction to review the QExA contract because the contract executed between DHS and Ohana was not a contract of insurance.

On March 18, 2009, the Petition was heard and argued before hearings officer Thomas M. Pico, Jr.[9] On April 27, 2009, the hearings officer issued his Recommended Decision. On June 2, 2009, the Insurance Commissioner issued his Decision, relying on the hearings officer's Recommended Decision. The Decision contained Findings of Fact (FOFs) that discussed the terms of the QExA contracts and recounted the RFP process. The Decision also contained the following Conclusions of Law (COLs):

> 1. Petitioner is an "interested party" and so had standing to file this Petition for declaratory relief pursuant to [HAR] § 16-201-48.
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> 2. Petitioner is also an "aggrieved person" within the meaning of HAR § 16-201-2, because Petitioner will be "adversely affected" by a decision of the Commissioner with respect to the type of license required to offer the QExA plan since a finding by the Commissioner that [United] and/or [Ohana] are properly licensed to perform the services required under the QExA contracts in issue . . . is effectively a finding that those entities can compete against Petitioner for an award of the QExA contract in issue.
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> 3. HAR § 16-201-50(1)[10] requires that a petition for

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[9] The agency record on appeal does not contain a transcript of the March 18, 2009 hearing.

[10] HAR § 16-201-50(1) (1990) provides:

> The authority, as expeditiously as possible after the filing of a petition for declaratory relief, shall:
>
> (1) Deny the petition where:

(continued...)

declaratory relief be denied where "[t]he matter is not within the jurisdiction of the authority" and where "[t]he petition is based on hypothetical or speculative facts of either liability or damages." Cf. Citizens Against Reckless Development v. Zoning Bd. of Appeals, 114 Hawaii 184, 194-95, 159 P.3d 143, 153-54 (2007) (explaining that an administrative agency has discretion to deny declaratory relief on a ground enumerated in an agency rule). The Petition raised issues of interpretation of the Hawaii Insurance Code that are within the jurisdiction of the Hawaii Insurance Commissioner to interpret.

4. The QExA contracts entered into by DHS with [Ohana] and [United] are not contracts of insurance. HRS § 431:1-201(a) provides that "[i]nsurance is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies." Accordingly, determining the validity of the QExA contracts is not the business of insurance and is outside the jurisdiction of the Commissioner. Except for relief in the form of a declaration that neither [United] nor [Ohana] are properly licensed to perform the services required under the QExA contract, all other claims for relief based upon allegations of the Petition regarding the validity of the contracts entered into by DHS with [Ohana] and [United] are denied as beyond the jurisdiction of the authority. HAR § 16-201-50(l)(C).

5. The Petition also relies upon speculative and hypothetical allegations regarding actions which may (or may not) be taken by the Centers for Medicare & Medicaid Services ("CMS"). Relief based upon those allegations is denied pursuant to HAR

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[10](...continued)
(A) The petition fails to conform substantially with section 16-201-48 or is not supported by a memorandum of law in support of the petition;

(B) The petition is frivolous;

(C) The matter is not within the jurisdiction of the authority;

(D) The petition is based on hypothetical or speculative facts of either liability or damages;

(E) There is a genuine controversy of material fact, the resolution of which is necessary before any order or declaratory relief may issue; or

(F) There is any other reason justifying denial of the petition.

§ 16-201-50(1)(D). Cf. Bremner v. City & County of Honolulu, 96 Hawaii 134, 144,28 P.3d 350, 360 (App. 2001) (speculative nature of concerns regarding how city would administer ordinance and effect of ordinance led court to conclude that matter was not ripe for adjudication).

6. The issue to be decided in this matter is whether a license issued pursuant to the Health Maintenance Organization Act, HRS Chapter 432D ("the HMO Act") is required to perform the QExA contract. If so, neither [United] nor [Ohana] are properly licensed to perform the services required under the QExA contracts.

7. The determination of the issue to be decided in this matter involves interpretation of HRS §§ 431:1-201, 431:1-205 and HRS Chapters 432D, 432E, and 431:l0A. All of these statutes are within the jurisdiction of the Insurance Commissioner.

8. Insurance is "a contract whereby one party undertakes to indemnify another or pay a specified amount upon determinable contingencies[."] HRS § 431:1-201. Under this general definition, there are several classes of insurance, one of which is accident and health and sickness insurance. Accident and health insurance, as defined in HRS § 431:1-205, is "insurance against bodily injury, disablement, or death by accident,· or accidental means, or the expense thereof; against disablement or expense resulting from sickness; and every insurance appertaining thereto, including health and medical insurance." [Ohana] and [United] are each licensed as risk-bearing entities to provide accident and health or sickness insurance pursuant to HRS Chapter 431:10A but not Chapter 432D, the HMO Act.

9. The QExA plan is also governed by federal law relating to the Medicaid program. The Social Security Act § 1903(m) and federal regulation at 42 C.F.R § 438.116(b)(l) expressly state that a Medicaid managed care organization ("MCO") may be either a federally qualified HMO or "be licensed or certified by the State as a risk bearing entity."

10. Hawaii law does not support a conclusion that the QExA plan must be provided by an HMO because the QExA program does not require the entity to provide services that can only be provided by an HMO under Hawaii law.

11. HRS § 432E-1 defines a "managed care plan" to mean "any plan, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a health insurance issuer, a fiscal intermediary, a payor, a prepaid health care plan, and

any other mixed model, that provides for the financing or delivery of health care services or benefits to enrollees through:

> (1) Arrangements with selected providers or provider networks to furnish health care services or benefits; and
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> (2) Financial incentives for enrollees to use participating providers and procedures provided by a plan;
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> provided, that for the purposes of this chapter, an employee benefit plan shall not be deemed a managed care plan with respect to any provision of this chapter or to any requirement or rule imposed or permitted by this chapter which is superseded or preempted by federal law."

12. HRS § 432D-1 defines a "health maintenance organization" to mean "any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments, deductibles, or both."

13. HRS § 432D-2(a) provides that "[n]o person shall establish or operate a health maintenance organization in this State without obtaining a certificate of authority under this chapter." There is no definition of what it means to "operate a health maintenance organization" in Chapter 432D HRS. Nor is there any definition of "HMO activities" or "HMO product."

14. The term "operate a health maintenance organization" as used in HRS § 432D-2(a) is thus interpreted to mean engaging in activities which only an HMO is authorized to do. If a risk bearing entity licensed by the Insurance Division under a statute other than HRS Chapter 432D is authorized to engage in the activities it has undertaken by the statute pursuant to which it is licensed, it is not by virtue of its engaging in permitted activities, "operat[ing] a health maintenance organization" within the prohibition of HRS § 432D-2(a).

15. The definition of a "managed care plan" in HRS § 432E-1 encompasses all types of plans that provide for the financing or delivery of health care services that meet the criteria of that section, including HMOs licensed under HRS Chapter 432D and risk bearing entities licensed under HRS Chapter 431:10A.

16. There is substantial overlap between the powers granted to health maintenance organizations under HRS Chapter 432D and entities licensed under HRS Chapter 431:10A. The key distinction is that HMOs are the only licensed entities that may furnish health care directly to their members through facilities that it

owns or operates and utilizing the services of physicians employed by the HMO and require that coverage is only provided when a member either utilizes its facilities and providers or is specifically authorized by its providers to utilize outside facilities or providers. An entity licensed as an HMO is not limited to furnishing care directly to its members through its owned facilities and employed providers, but it is authorized to do so. That authorization distinguishes entities licensed as HMOs from other risk-bearing entities licensed by the Insurance Commissioner in the State of Hawaii. Conversely, risk bearing entities licensed under HRS Chapter 431:10A are prohibited from requiring that "service[s] be rendered by a particular hospital or person." HRS § 431:10A-205(b). For AlohaCare to prevail in this matter, the law would have to define an HMO in terms of having a closed panel. The law simply does not do so.

17. HRS Chapter 393, the Hawaiʻi Prepaid Health Care Act, confirms that a distinguishing feature of an HMO is its ability to furnish care directly to its members. In defining what constitutes a "prepaid health care plan," HRS § 393-3 distinguishes plans which "furnish" health care from plans which "defray or reimburse, in whole or in part, the expenses of" health care. The prevalent plan in Hawaii of the type which "furnishes" health care is the HMO offered by Kaiser Foundation Health Plan, Inc.

18. The rules of statutory interpretation avoiding implied amendment or repeal further support the conclusion that, so long as a risk bearing entity licensed by the Insurance Division under a statute other than HRS Chapter 432D is authorized to engage in the activities it has undertaken by the statute pursuant to which it is licensed, it is not by implication prohibited from doing so by HRS § 432D-2(a).

19. Had the QExA program been designed solely for HMOs, the enrollees would have been limited to health care services furnished directly to QExA enrollees through facilities owned or operated by the HMO, and utilizing the services of physicians employed by the HMO.

20. Both [United] and [Ohana] are licensed as risk-bearing entities pursuant to HRS Chapter 431:10A. There is no prohibition under Hawaii law which prevents an insurer licensed under HRS Chapter 431:10A from offering the closed panel product required by the QExA RFP.

21. HRS § 431:10A-205(b) states that "[a]ny group or blanket disability policy may provide that all or any portion of any indemnities provided by the policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid

directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount so paid." ([Emphasis] added).

22. Insurers licensed pursuant to HRS Chapter 431:10A are not authorized to "require that the [covered health care] service be rendered by a particular hospital or person." The plain meaning of the statute prohibits a restriction that limits insureds to receiving care from "a particular," or a single, designated hospital or person.

23. Insurers licensed under HRS Chapter 431:10A are not prohibited from offering a closed panel or limited physician group model of care by HRS § 431:10A-205(b) as long as there is a choice of providers and hospitals for its members.

24. There is nothing in the legislative history of HRS § 431:10A-205(b) to support an interpretation of the provision as precluding the offering of a closed panel product such as that required by the QExA program. That provision has remained virtually unchanged since it was enacted in 1955, while Hawaii was still a territory.

25. The statutory language cannot have been intended to prohibit closed panel or limited physician group models of care, as those managed care models have only developed in recent times. Moreover, if the Legislature had intended to prohibit insurers from requiring that services be obtained from a defined network of providers, the statutory language would have used the plural form instead of the singular ("particular hospitals or persons").

26. The language used in 1955 was taken from a model law proposed by the National Association of Insurance Commissioners. It is statutory language of differentiation, by which policy designs that would permit the insurer to direct the destiny of the cure through the specific designation of the person or facilities are prohibited. The phrase "may not require that the service be rendered by a particular hospital or person" distinguishes accident and sickness policy standards from the standards of the Workmens' Compensation Laws common at that time that expressly permitted an employer to select for the treatment of his employee, specific physicians, hospitals and even specific nurses. (See, Insurance Com'rs v. Mutual Medical Ins., Inc., 251 Ind. 296, 241 N.E.2d 56 (1968)).

27. HRS § 431:10A-205(b) was intended to prevent insurance companies from requiring that their insureds receive their care from a single hospital or physician under contract with the insurer. Based on the plain

> language and the legislative history of HRS § 431:10A-205(b), there is no reason to conclude the statute was intended to prohibit insurers from offering a closed panel product with the choice of providers required by the QExA.
>
> 28. The fact that the QExA RFP provided for reimbursement to qualifying health plans at fully capitated rates did not require that those QExA plans be licensed as HMOs in the State of Hawaii.
>
> 29. Petitioner had both the burden of proof and the burden of persuasion. Petitioner has failed to carry its burden of proof and persuasion regarding its allegations. There is no legal basis for concluding that an HMO license is required for [United] and [Ohana] to offer the QExA plan.

(Some brackets in original and some added) (record citations omitted) (some formatting altered) (emphasis in original).

Based on the Decision's FOFs and COLs, the Insurance Commissioner ordered that:

> 1. The Amended Motion to Dismiss filed by DHS on December 8, 2008, is denied on the grounds that the Commissioner has jurisdiction; and,
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> 2. An HMO license is not required to offer the QExA managed care plan. The QExA managed care plan may be offered by any risk-bearing entity licensed by the Insurance Division, [DCCA], State of Hawaii; and
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> 3. There is no legal or factual grounds for relief under the Petition, and thus all relief requested in the Petition is denied.

D. Appeal to the circuit court

On July 2, 2009, AlohaCare timely appealed the Insurance Commissioner's Decision to the circuit court pursuant to HRS § 91-14.[11] AlohaCare argued that it was an "aggrieved

[11] HRS § 91-14 (2004) provides, in pertinent part:

> (a) Any person aggrieved by a final decision and order in a contested case or by a preliminary ruling of the nature that deferral of review pending entry of a subsequent final decision would deprive appellant of adequate relief is entitled to judicial review thereof

(continued...)

person" as that term is used in HAR § 16-201-2 because it was "adversely affected by the Insurance Commissioner's decision."[12] AlohaCare's arguments on the merits centered on the contention that the HMO Act requires an entity to have an HMO license in order to conduct "HMO activities[.]"

United[13] argued, inter alia, that AlohaCare's interpretation of the HMO Act, which was passed in 1995, improperly nullified a portion of the definition of a "managed care plan" in the Patients' Bill of Rights and Responsibilities Act (hereinafter Patients' Bill of Rights Act), which was passed in 1998.[14] The Insurance Commissioner argued, inter alia, that

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[11](...continued)

> under this chapter; but nothing in this section shall be deemed to prevent resort to other means of review, redress, relief, or trial de novo, including the right of trial by jury, provided by law. Notwithstanding any other provision of this chapter to the contrary, for the purposes of this section, the term "person aggrieved" shall include an agency that is a party to a contested case proceeding before that agency or another agency.

(Emphasis added).

[12] This argument was made in AlohaCare's Statement of the Case. AlohaCare's opening brief to the circuit court did not address its standing to appeal the Insurance Commissioner's Decision.

[13] Ohana and DHS joined United's Answering Brief to the circuit court.

[14] The Patients' Bill of Rights Act defines a "[m]anaged care plan" as:

> "Managed care plan" means any plan, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a

(continued...)

AlohaCare was not a "person aggrieved" under HRS § 91-14(a) and lacked standing to appeal because "the purported interest of AlohaCare in having a competitive advantage from its HMO license is not a legally protected interest sufficient to confer standing . . . under HRS chapter 91."

On July 28, 2009, DHS filed a motion to dismiss for lack of jurisdiction arguing, inter alia, that AlohaCare did not have standing to appeal pursuant to HRS § 91-14 because it was not an "aggrieved person," and HRS chapter 432D does not confer a private right of action that AlohaCare could enforce. In response, AlohaCare argued that it had standing to appeal as an aggrieved person.[15]

On September 16, 2009, the circuit court held a hearing on DHS's motion. At the outset of the hearing, AlohaCare

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[14](...continued)

> payor, a prepaid health care plan, and any other mixed model, that provides for the financing or delivery of health care services or benefits to enrollees through:
>
> > (1) Arrangements with selected providers or provider networks to furnish health care services or benefits; and
> >
> > (2) Financial incentives for enrollees to use participating providers and procedures provided by a plan;
>
> provided, that for the purposes of this chapter, an employee benefit plan shall not be deemed a managed care plan with respect to any provision of this chapter or to any requirement or rule imposed or permitted by this chapter which is superseded or preempted by federal law.

HRS § 432E-1 (2000) (emphasis added).

[15] AlohaCare did not argue that it had standing to appeal as an "interested person" pursuant HRS § 91-8.

clarified that, although AlohaCare's petition for declaratory relief was brought pursuant to HRS § 91-8, its appeal of that ruling was brought pursuant to HRS § 91-14. United argued that:

> In the proceeding before the Insurance Commissioner, the petition for declaratory relief, it was sufficient for AlohaCare to be an interested party, and it could proceed as an interested party. In that proceeding, there's a different standard. Aggrieved is a different level of involvement, a different level of impact. And so that was the argument that we made below, that certainly they're an interested party, the Commissioner can go ahead and decide the issue because it's an important issue, but that AlohaCare was not aggrieved because it just simply failed to meet the definition of an aggrieved party. And under [HRS §] 91-14, I believe a party has to be aggrieved in order to have a right to appeal. That was the distinction.

(Emphasis added).

United further argued that:

> only that subset of interested persons that are actually aggrieved . . . is going to be allowed access to the courts in an appeal. So it's not as if no one that files a declaratory relief petition can seek appellate review . . . . The way it works together is that you can't be merely interested. You must also be aggrieved in order to take up the resources of the Judiciary in an appellate setting.

DHS agreed with United, and argued that, "under [HRS §] 91-8, an interested party can bring a declaratory relief action or a declaratory judgment action. But in order to [appeal to circuit court], you have to be an aggrieved person, not an interested person or interested party."

Although AlohaCare argued that declaratory rulings under HRS § 91-8 were appealable to the circuit court under HRS § 91-14 pursuant to Lingle v. Hawaii Government Employees Association, 107 Hawaiʻi 178, 111 P.3d 587 (2005), it did not

argue that it could appeal the Insurance Commission's Decision without being aggrieved. Nevertheless, AlohaCare argued that the Insurance Commissioner's determination that AlohaCare had "two bases for standing below," i.e., as an interested party and as an aggrieved party, was not clearly erroneous.

AlohaCare further argued that it was aggrieved because it suffered an actual or threatened injury, which was traceable to the Insurance Commissioner's Decision, and that a favorable decision would provide relief for its injury. With regard to its actual or threatened injury, AlohaCare argued that the Insurance Commissioner's Decision would "impact AlohaCare's business in the future[,]" and that AlohaCare faced burdens in excess of those faced by its competitors because it was required to maintain its HMO license. AlohaCare conceded that the Insurance Commissioner's Decision could not declare United's and Ohana's QExA contracts null and void, but that

> [t]he effect of what the Insurance Commissioner would decide would have an impact on DHS and their requirement that the entity be properly licensed. In other words, their RFP says you have to be properly licensed. If [the circuit court] or the Insurance Commissioner said they're not properly licensed, that ends their contract. But . . . this ruling goes beyond simply that particular contract. It affects the whole operation of AlohaCare in the future.

The circuit court took the matter under advisement, noting that, "[i]f there is a showing of aggrieved party as that is understood under [HRS § 91-14], then I will have jurisdiction[.]" On September 29, 2009, the circuit court entered a minute order, stating its intent to deny the motion and

noting that "the court is persuaded on the basis of the rationale in [Lingle] that the court has jurisdiction over this matter[.]" On October 22, 2009, the circuit court filed an order denying the motion without providing further reasoning.[16]

On December 23, 2009, the circuit court heard oral argument on the merits of AlohaCare's appeal and orally affirmed the Decision of the Insurance Commissioner, on the ground that the Decision was entitled to deference and "properly interpreted" the statutes "to require reconciliation of the overlapping structure[.]" The circuit court's decision and order affirming the Insurance Commissioner's June 2, 2009 Decision, Findings of Fact, Conclusions of Law and Order, was filed on December 28, 2009. The circuit court's judgment was also filed on December 28, 2009.

E. Appeal to the ICA

AlohaCare timely filed a Notice of Appeal to the ICA on January 5, 2010 and the appeal was fully briefed in the ICA. AlohaCare's application for transfer of the appeal to this court was accepted on October 12, 2010.

1. AlohaCare's opening brief

In its opening brief, AlohaCare argues that "[t]he HMO Act requires an entity that meets that Act's description of an

[16] Subsequently, during argument on the merits of the appeal, the circuit court explained that "[AlohaCare] is aggrieved in a sense that the context in which the matter arises is one that impacts potential future competition."

HMO to obtain a certificate of authority (license) from the Insurance Commissioner prior to engaging in an HMO Act covered activity." In support of this argument, AlohaCare contends that the "legislature that passed the HMO Act did so based on an understanding that the 'field' of activities to which the Act applied (and for which it required a license) was not then subject to State insurance regulation" and that the April 24, 2008 letter from the Insurance Division to United "was the exact opposite of the understanding of the legislature that passed the HMO Act."

Next, AlohaCare contends that the Insurance Commissioner's Decision reaches inconsistent conclusions. For example, AlohaCare notes that "the [D]ecision holds that although [Ohana] and United are licensed or certified as risk-bearing entities, the certification or license both hold does not extend to their conduct under their QExA contracts."[17] As such, "they were and are performing their QExA contracts under no licensing authority."

Finally, AlohaCare argues that the Decision ignored canons of statutory construction when it considered the overlap between HRS chapter 431:10A and HRS chapter 432D. Specifically,

[17] This statement somewhat misstates the Insurance Commissioner's conclusion. As noted supra, the Insurance Commissioner held in COL 4 that "[t]he QExA contracts entered into by DHS with [Ohana] and [United] are not contracts of insurance." However, as discussed infra, United and Ohana's conduct under their QExA contracts with QExA members does involve the provision of insurance.

AlohaCare argues that the plain language of the HMO Act is clear and unambiguous and the Insurance Commissioner should not have departed from the clear and unambiguous language. AlohaCare further argues that even if the terms in HRS chapter 432D could be construed as ambiguous, "the proper course of action is to look to a dictionary to determine the ordinary meaning." Accordingly, AlohaCare argues that the Decision "is contrary to [the] unambiguous language of the HMO Act and contravenes the legislature's stated intent of regulating HMOs in Hawaii." Finally, AlohaCare argues the HMO Act should be given full effect because the HMO Act "'covers the whole subject which it relates,' all the way down to telling indemnity insurance licensees what to do to be HMOs."

2. United's arguments

United[18] contends that it and Ohana are properly licensed to provide the QExA program. United makes three points in support of this contention. First, United states that the QExA program expressly called for a "managed care program," not a managed care program provided by an HMO, and that the services required under the QExA contract are not "HMO activity" – "a term made up by AlohaCare that appears nowhere in the HMO Act or its legislative history." Second, United contends that "AlohaCare's interpretation of the HMO Act would require that all health plan

[18] Ohana joined United's Answering Brief.

coverage required to be provided by employers under the Hawaiʻi Prepaid Health Care Act, HRS [c]hapter 393, be provided by a licensed HMO." Third, United argues that "AlohaCare's interpretation of the HMO Act would improperly nullify a later enacted statute, HRS [c]hapter 432E, whereas the Commissioner's interpretation successfully reconciled these two statutes and gave meaning to both."

United also argues that the "Commissioner's Decision is supported by established rules of statutory construction" and that the language of the HMO Act is not clear and unambiguous. United also contends that using a dictionary to define terms in HRS chapter 432D is not helpful, since "the issue [is] whether it [is] possible to construe [HRS chapters] 432D, 432E and 431:10A in such a way so as to give all of the statutes reasonable meaning and to avoid implied amendment or repeal." Finally, United argues that the Insurance Commissioner's Decision is entitled to deference.

3. Insurance Commissioner's arguments

The Insurance Commissioner puts forth five arguments in its answering brief. First, the Insurance Commissioner argues that this court lacks jurisdiction to consider the appeal because AlohaCare is not a "person aggrieved" under HRS § 91-14(a). Second, the Insurance Commissioner argues that AlohaCare fails to show that "its substantial rights were prejudiced[,]" and

therefore reversal is not warranted under HRS § 91-14(g).[19] Instead, the Insurance Commissioner argues that "[n]othing about any license or other interest of AlohaCare was at issue in the declaratory relief proceedings[,]" since the Decision "was that third party entities [Ohana and United] could perform the services specified in the DHS QExA RFP."

Third, the Insurance Commissioner contends that where, as in this case, the Petition is based on hypothetical or speculative facts, it is within the Commissioner's discretion to deny the Petition pursuant to HAR § 16-201-50. The Insurance Commissioner argues that because COL 5, which found that certain allegations in the Petition relied "upon speculative and hypothetical allegations regarding actions which may (or may not)

[19] HRS § 91-14(g) provides:

> Upon review of the record the court may affirm the decision of the agency or remand the case with instructions for further proceedings; or it may reverse or modify the decision and order if the substantial rights of the petitioners may have been prejudiced because the administrative findings, conclusions, decisions, or orders are:
>
> (1) In violation of constitutional or statutory provisions; or
>
> (2) In excess of the statutory authority or jurisdiction of the agency; or
>
> (3) Made upon unlawful procedure; or
>
> (4) Affected by other error of law; or
>
> (5) Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
>
> (6) Arbitrary, or capricious, or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

be taken by the Centers for Medicare & Medicaid Services[,]" was unchallenged, the Petition was correctly denied.

Next, the Insurance Commissioner argues that because AlohaCare did not challenge the FOFs and COLs that support the Commissioner's Decision, AlohaCare's "points on appeal" are in contravention of Hawaii Rules of Appellate Procedure (HRAP) 28(b)(4)(C).[20] Finally, the Insurance Commissioner argues that his interpretation and application of the statutes is entitled to deference.

4. DHS's arguments

In its answering brief, DHS primarily argues that AlohaCare does not have standing to appeal because it is not an "aggrieved person."[21] DHS also contends that AlohaCare does not

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[20] HRAP 28(b)(4) provides that opening briefs shall contain:

> [a] concise statement of the points of error set forth in separately numbered paragraphs. Each point shall state: (i) the alleged error committed by the court or agency; (ii) where in the record the alleged error occurred; and (iii) where in the record the alleged error was objected to or the manner in which the alleged error was brought to the attention of the court or agency. Where applicable, each point shall also include the following:
>
> . . .
>
> (C) when the point involves a finding or conclusion of the court or agency, either a quotation of the finding or conclusion urged as error or reference to appended findings and conclusions[.]

[21] DHS also argues, without citation to case law or the record, that "the decision of the Chief Procurement Officer is now res judicata, and AlohaCare is not entitled to relitigate this issue." (Emphasis in original). Because DHS does not present a discernible argument regarding res judicata, we do not address res judicata further. See, e.g., State v. Mark, 123 Hawaiʻi 205, 247, 231 P.3d 478, 520 (2010) (stating that if a party fails to

(continued...)

have standing because HRS chapter 432D does not create a private right of action.[22] Third, DHS argues that AlohaCare does not have standing because, it is not a party or third party beneficiary of the QExA contract that may, under Hawaiʻi case law, statute, rule, or regulation, seek a declaration that the contract is "'null and void' due to alleged 'illegality.'"

DHS next argues that AlohaCare waived its argument that United's and Ohana's lack of HMO licenses disqualified them as successful bidders for the QExA RFP because AlohaCare did not raise this issue in its initial protest of the award to the DHS Director in February 2008, which was subsequently upheld by the Chief Procurement Officer.[23] Finally, DHS argues, without citation to case law or the record, that the Insurance Commissioner should not have conducted a hearing on AlohaCare's Petition because the Insurance Commissioner "should have

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[21](...continued)
explicitly explain an argument, an appellate court need not address matters as to which the party has failed to present a discernible argument and the argument may be disregarded).

[22] Specifically, DHS asserts that no private right of action exists because: 1) AlohaCare is not one of the class for whose especial benefit HRS chapter 432D was enacted; 2) no legislative history evidencing an intent to create the remedy sought by AlohaCare exists; and 3) AlohaCare's remedy of requesting this court to "enforce" the plain meaning of HRS § 432D-2(a) and "decide" that an HMO license is required to conduct the QExA program is inconsistent with the underlying purposes the legislature contemplated when enacting HRS chapter 432D.

AlohaCare did not respond to DHS' argument in its reply brief to the Insurance Commissioner and DHS. As discussed infra in note 31, DHS's argument is without merit.

[23] This argument relates to AlohaCare's challenge to the procurement process, discussed supra in note 4. Notably, DHS' current argument contrasts with its position before the hearings officer, to whom DHS asserted that AlohaCare "previously raised the State of Hawaii licensing issue with the State Procurement Officer."

recognized [AlohaCare's] true purpose" of attempting to "overturn the decision of the Procurement Officer, and evade the exclusive remedy set by the state legislature[]" such that any appellate review of that decision is improper.

5. AlohaCare's reply briefs

In its reply to DHS's and the Insurance Commissioner's answering briefs,[24] AlohaCare argues that it has standing and that the circuit court had jurisdiction over its appeal because it was aggrieved "as that term is used in HRS § 91-14(a)," and because this court held in Lingle that "rulings disposing of declaratory actions have the same status as other agency orders" and are therefore appealable pursuant to HRS § 91-14. In conclusion, AlohaCare asserts that "[t]his [c]ourt has jurisdiction to hear AlohaCare's appeal of the [c]ircuit [c]ourt decision because AlohaCare is an aggrieved party, and, as such, it is afforded the right to appeal by HRS §§ 91-8 and 91-14."

II. Standards of Review

A. Standing

"Whether the circuit court has jurisdiction to hear the plaintiffs' complaint presents a question of law, reviewable de novo. A plaintiff without standing is not entitled to invoke a court's jurisdiction. Thus, the issue of standing is reviewed de novo on appeal." Hawaii Med. Ass'n v. Hawaii Med. Serv. Ass'n,

[24] AlohaCare filed a separate reply to United's answering brief, in which it argued that the HMO Act "comprehensively and exclusively regulates" entities that "do what licensed HMOs are authorized by that Act . . . to do."

Inc., 113 Hawaiʻi 77, 90, 148 P.3d 1179, 1192 (2006) (citing Mottl v. Miyahira, 95 Hawaiʻi 381, 388, 23 P.3d 716, 723 (2001)) (formatting altered).

B. Secondary judicial review of an administrative decision

"On secondary judicial review of an administrative decision, Hawaii appellate courts apply the same standard of review as that applied upon primary review by the circuit court." Kaiser Found. Health Plan, Inc. v. Dep't of Labor & Indus. Relations, 70 Haw. 72, 80, 762 P.2d 796, 800-01 (1988). For administrative appeals, the applicable standard of review is set forth in HRS § 91-14(g) (2004), which provides:

> Upon review of the record the court may affirm the decision of the agency or remand the case with instructions for further proceedings; or it may reverse or modify the decision and order if the substantial rights of the petitioners may have been prejudiced because the administrative findings, conclusions, decisions, or orders are:
>
> (1) In violation of constitutional or statutory provisions; or
>
> (2) In excess of the statutory authority or jurisdiction of the agency; or
>
> (3) Made upon unlawful procedure; or
>
> (4) Affected by other error of law; or
>
> (5) Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
>
> (6) Arbitrary, capricious, or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Pursuant to HRS § 91-14(g)(5),

> administrative findings of fact are reviewed under the clearly erroneous standard, which requires [the appellate] court to sustain its findings unless the court is left with a firm and definite conviction that a mistake has been made. Administrative conclusions

> of law, however, are reviewed under the de novo standard inasmuch as they are not binding on an appellate court. Where both mixed questions of fact and law are presented, deference will be given to the agency's expertise and experience in the particular field and the court should not substitute its own judgment for that of the agency. To be granted deference, however, the agency's decision must be consistent with the legislative purpose.

Peroutka v. Cronin, 117 Hawaiʻi 323, 326, 179 P.3d 1050, 1053 (2008) (citations and internal quotation marks omitted).

C. Statutory interpretation

"Questions of statutory interpretation are questions of law reviewable de novo." Gump v. Wal-Mart Stores, 93 Hawaiʻi 417, 420, 5 P.3d 407, 410 (2000) (formatting altered).

III. Discussion

As a threshold matter, we hold that AlohaCare has standing to appeal the Insurance Commissioner's Decision. Regarding the merits, we hold that both accident and health insurers and HMOs are authorized pursuant to their licensing schemes to offer the closed panel or limited physician group model of care as required by the QExA contracts. We conclude that this holding does not nullify the HMO Act.[25] Accordingly, we

[25] The parties disagree whether the Insurance Commissioner's Decision is entitled to deference. "Where an agency is statutorily responsible for carrying out the mandate of a statute which contains broad or ambiguous language, that agency's interpretation and application of the statute is generally accorded judicial deference on appellate review." Haole v. State, 111 Hawaiʻi 144, 150, 140 P.3d 377, 383 (2006) (quoting Vail v. Emps. Ret. Sys., 75 Haw. 42, 59, 856 P.2d 1227, 1237 (1993)). However, "an interpretation by an agency of a statute it administers is not entitled to deference if the interpretation is plainly erroneous and inconsistent with both the letter and intent of the statutory mandate." Id. (citing Kahana Sunset Owners v. County of Maui, 86 Hawaiʻi 66, 72, 947 P.2d 378, 384 (1997)). As set forth below, the Insurance Commissioner's analysis is correct. Accordingly, we need not further address whether deference should be accorded.

affirm the judgment of the circuit court.

A. AlohaCare is a "person aggrieved" and has standing to appeal

AlohaCare brought its petition for declaratory relief as an "interested person" pursuant to HRS § 91-8. HRS § 91-8 allows "[a]ny interested person [to] petition an agency for a declaratory order as to the applicability of any statutory provision or of any rule or order of the agency." However, HRS § 91-8 does not address the procedures or requirements for the appeal of an agency's declaratory order. Instead, those procedures and requirements are set forth in HRS § 91-14.[26] See HRS § 91-14; Lingle, 107 Hawaiʻi at 186, 111 P.3d at 595 (noting that "orders disposing of petitions for declaratory rulings under HRS § 91-8 are appealable to the circuit court pursuant to HRS § 91-14").

HRS § 91-14(a) provides that "[a]ny person aggrieved by a final decision and order in a contested case . . . is entitled to judicial review thereof under [chapter 91.]" (Emphasis added). This court has recognized that judicial review of orders disposing of petitions for declaratory rulings pursuant to HRS § 91-8 are also subject to judicial review, although those orders may not result from contested cases. Lingle, 107 Hawaiʻi at 185, 111 P.3d at 594. Put another way, an order disposing of a

[26] We therefore respectfully disagree with the dissent's assertion that AlohaCare may appeal the Insurance Commissioner's decision "under HRS § 91-8." See dissenting opinion at 24-25, 41, 45. Moreover, we note that AlohaCare indicated in the circuit court that its appeal was brought pursuant to HRS § 91-14.

petition for a declaratory ruling brought pursuant to HRS § 91-8 fulfills the requirement in HRS § 91-14(a) that the decision or order at issue be entered "in a contested case."

In the instant case, it is undisputed that the Insurance Commissioner's Decision did not result from a "contested case." See HRS § 91-1(5) (defining a contested case as "a proceeding in which the legal rights, duties, or privileges of specific parties are required by law to be determined after an opportunity for agency hearing"). Nevertheless, the Insurance Commissioner's Decision was appealable pursuant to HRS § 91-14, because it was an order disposing of a petition brought pursuant to HRS § 91-8. Lingle, 107 Hawaiʻi at 185, 111 P.3d at 594. In addition, as set forth below, Alohacare is a "person aggrieved" by the Insurance Commissioner's Decision, because it faced increased competition from allegedly improperly licensed competitors in the QExA contract process, and the Decision held that AlohaCare's competitors were in fact properly licensed to offer the services required under those contracts. See HRS § 91-14(a). Accordingly, AlohaCare has standing to appeal the Insurance Commissioner's Decision.

1. AlohaCare is a "person aggrieved" because it suffered an injury-in-fact

HRS chapter 91 does not define the term "person aggrieved," but this court has noted that "'person aggrieved' appears to be essentially synonymous with someone who has

suffered 'injury in fact.'" E & J Lounge Operating Co. v. Liquor Comm'n of the City and Cnty. of Honolulu, 118 Hawaiʻi 320, 345 n.35, 189 P.3d 432, 457 n.35 (2008) (citation and some quotation marks omitted). Whether a party has suffered an "injury in fact" is determined under a three-part test: "(1) whether the person 'has suffered an actual or threatened injury as a result of the [agency's decision],' (2) whether 'the injury is fairly traceable to the [agency's decision],' and (3) whether 'a favorable decision would likely provide relief for [the person's] injury.'" Id. (some brackets added and some in original) (quoting Keahole Def. Coal., Inc. v. Bd. of Land & Natural Res., 110 Hawaiʻi 419, 434, 134 P.3d 585, 600 (2006)).

In its reply brief, AlohaCare argues that it suffered an "actual or threatened injury" on two grounds. First, AlohaCare agrees with the Insurance Commissioner's determination that AlohaCare was aggrieved because "a finding by the Commissioner that [United] and/or [Ohana] are properly licensed to perform the services required under the QExA contracts in issue . . . is effectively a finding that those entities can compete against [AlohaCare] for an award of the QExA contract in issue." Second, AlohaCare contends that its HMO license has been "taken away" or "substantially diminished" by the Insurance Commissioner's Decision.[27] AlohaCare argues that this effect on

[27] AlohaCare's arguments that the Insurance Commissioner's Decision "strips [it] of its license" and that its license was "taken away" are not (continued...)

its license "is not limited to QExA, but applies to any activity which involves arranging for the delivery of health care services."

AlohaCare's argument concerning the effect of the Decision on its other activities is not supported by the record. Neither the record on appeal nor the administrative record on appeal contain any documents, exhibits, or testimony that would establish AlohaCare's possible injury relating to other activities. See United Pub. Workers, Local 646, AFSCME, AFL-CIO v. Brown, 80 Hawaiʻi 376, 380-81; 910 P.2d 147, 151-52 (App. 1996) (holding that a union did not have standing because its asserted possible injuries of future "charges" or "civil suits against the Union" that could affect its financial resources were not demonstrated in the record through documents, exhibits or testimony). Accordingly, this injury is not sufficient to establish that AlohaCare is a "person aggrieved[.]"

However, as noted by the Insurance Commissioner, AlohaCare was "adversely affected" by the Decision "with respect to the type of license required to offer the QExA plan" because the conclusion that United and Ohana are properly licensed to perform the services required under the QExA contracts "is

[27](...continued)
supported by the record. The Decision did not make a determination regarding AlohaCare's license, revoke AlohaCare's license, or limit AlohaCare's ability to operate an HMO. AlohaCare may still participate in the business it has chosen by "provid[ing] or arrang[ing] for the delivery of basic health care services to enrollees on a prepaid basis," as set forth in HRS § 432D-1.

effectively a finding that those entities can compete against [AlohaCare] for an award of the QExA contract in issue." Accordingly, AlohaCare sustained a concrete injury because it faced increased competition from allegedly improperly licensed competitors in the QExA contract process, and the Decision held that AlohaCare's competitors were in fact properly licensed to offer the services required under those contracts.[28]

In addition, AlohaCare's injury of increased competition by allegedly improperly licensed competitors for the award of the QExA contract is fairly traceable to the Decision, see E & J Lounge, 118 Hawaiʻi at 346 n.35, 189 P.3d at 458 n.35, because the Decision held that United and Ohana were properly licensed to perform the services required under the QExA contracts.[29]

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[28] The Insurance Commissioner expressly noted that "determining the validity of the QExA contracts is not the business of insurance and is outside the jurisdiction of the Commissioner." Accordingly, the Insurance Commissioner denied AlohaCare's claims for relief that were "based upon allegations . . . regarding the validity of the contracts entered into by DHS with [Ohana] and [United.]"

We agree with the dissent that this conclusion was proper, and that the Insurance Commissioner did not have jurisdiction to declare the contracts null and void or issue a declaration as to whether DHS complied with the provisions of the RFP. See, e.g., dissenting opinion at 29-31. Instead, COLs 7 and 8 noted the proper basis for the Insurance Commissioner's jurisdiction, i.e., that the issue to be decided was whether an HMO license is required to perform the QExA contract and that "this matter involves interpretation of HRS §§ 431:1-201, 431:1-205, and HRS [c]hapters 432D, 432E and 431:10A." See HAR 16-201-2 (1990) (defining "declaratory relief" as "the authority's declaration as to the applicability or nonapplicability with respect to a factual situation of any rule or order of the authority or of a statute which the authority is required to administer or enforce") (emphasis added); HRS § 431:2-201(b) (2005) (providing that the Insurance Commissioner "shall enforce" the Insurance Code, HRS chapter 431).

[29] DHS contends that AlohaCare's injury is not traceable to the Decision because it was DHS, rather than the Insurance Commissioner, who selected United's and Ohana's bids over AlohaCare's bid. DHS further contends (continued...)

Finally, a favorable decision would provide AlohaCare relief from its injury. See E & J Lounge, 118 Hawaiʻi at 345 n.35, 189 P.3d at 457 n.35. If this court were to find that an HMO license is necessary to offer the services required under the QExA contracts, AlohaCare would be relieved of competition from United and Ohana in bidding for such contracts, unless United and Ohana obtained an HMO license.[30]

Based on the foregoing, AlohaCare is a "person aggrieved" that has standing to appeal pursuant to HRS § 91-14(a).[31]

[29](...continued)
that even if the Decision had been adverse to United and Ohana, AlohaCare would not have been awarded the contract because AlohaCare's bid proposal was rejected for not meeting the technical requirements of the RFP. However, DHS's arguments rest on the assumption that AlohaCare's injury was not being awarded a QExA contract. Instead, as noted above, AlohaCare's injury was facing increased competition by allegedly improperly licensed competitors in the QExA RFP process. This injury is fairly traceable to the Decision.

[30] Although the Insurance Commissioner was without jurisdiction to void the contracts, it is possible that such a decision might eventually result in the voiding of the contracts by DHS. In that regard, DHS argues that "AlohaCare would not attempt to bid on any new RFP (if it was issued)" because AlohaCare challenged the procurement process and therefore "has already taken the position that QExA is itself 'illegal[.]'" However, DHS's contention regarding AlohaCare's unwillingness to bid on a subsequent RFP is without support in the record.

[31] We further conclude that DHS's argument that HRS chapter 432D does not provide for a private cause of action is without merit. AlohaCare had a right to bring its petition for declaratory relief pursuant to HRS § 91-8 and HAR § 16-201-50 as an "interested person." Because AlohaCare was aggrieved by the Decision, AlohaCare had the right to appeal the Decision through the procedures set forth in HRS § 91-14(a).

2. We need not resolve whether an "interested person" may appeal an order entered on a petition brought pursuant to HRS § 91-8

Because we conclude that AlohaCare is a "person aggrieved," we need not resolve whether, as asserted by the dissent, AlohaCare had standing to appeal the Decision as an "interested person." See Richard v. Metcalf, 82 Hawaiʻi 249, 254, 921 P.2d 169, 174 (1996) (listing, "in order from the broadest to the narrowest category, the respective classes of potential litigants under HRS chapters 91 and 92" as "any person," "any interested person," and "persons aggrieved . . . in a contested case") (citations and footnote omitted). Moreover, we note that Alohacare has not argued that it has standing to appeal the Insurance Commissioner's Decision as an "interested person."[32] Finally, we note that the cases cited by the dissent, see dissenting opinion at 24-25, do not resolve, either expressly or impliedly, whether an "interested person" may appeal a declaratory order that did not result from a contested case.

For example, in Lingle, this court addressed whether the circuit court had jurisdiction, pursuant to HRS § 91-14, to review an agency's refusal to issue a declaratory order. 107 Hawaiʻi at 184-86, 111 P.3d at 593-95. The petitioners argued

[32] AlohaCare argued in the circuit court that, pursuant to Lingle, a HRS § 91-8 order disposing of a declaratory petition is appealable pursuant to HRS § 91-14. However, AlohaCare further argued that it was "aggrieved" by the Insurance Commissioner's Decision, and it did not argue that it could appeal without being aggrieved. AlohaCare continues to argue on appeal that it has standing because it is aggrieved by the Decision.

that the circuit court did not have jurisdiction because the order "did not result from a contested case." Id. at 183, 111 P.3d at 592. This court noted that it had "consistently recognized that circuit courts have jurisdiction, pursuant to HRS § 91-14, to review orders disposing of petitions for declaratory rulings." Id. at 185, 111 P.3d at 594 (citations omitted). This court explained that, pursuant to HRS § 91-8, "[o]rders disposing of petitions [for declaratory rulings] shall have the same status as other agency orders[,]" and that the phrase "other agency orders" was intended to "permit review of petitions for declaratory relief." Id. (some brackets in original and some added). Relying on legislative history, this court determined that the refusal to issue a declaratory order "in itself would be an agency order," and therefore would be reviewable. Id. Accordingly, this court held that the circuit court had jurisdiction over the agency appeal. Id. at 186, 111 P.3d at 595.

However, it does not appear that any of the parties in Lingle contested the appellants' standing to appeal,[33] and the basis for the appellants' standing, i.e., the question of whether an appellant must be "aggrieved" or merely "interested" to appeal a declaratory order, was not addressed. Id. at 184-86, 111 P.3d

[33] "[T]he standing inquiry focuses on whether a particular private party is an appropriate plaintiff." Cnty. of Hawaiʻi v. Ala Loop Homeowners, 123 Hawaiʻi 391, 406 n.20, 235 P.3d 1103, 1118 n.20 (2010) (emphasis in original) (citation omitted).

at 593-95; see also Vail v. Emps. Ret. Sys., 75 Haw. 42, 47, 52-66, 856 P.2d 1227, 1231, 1233-1240 (1993) (addressing an appeal of an agency's declaratory order on the merits, where the appellant's standing to seek judicial review was neither challenged nor discussed); Kim v. Emps. Ret. Sys., 89 Hawaiʻi 70, 73, 75-76, 968 P.2d 1081, 1084, 1086-87 (App. 1998) (same). Thus, we respectfully disagree with the dissent's conclusion that this court has "impliedly determined" that a party appealing a declaratory order need not be aggrieved. Dissenting opinion at 24. While Lingle and the cases cited therein determined that a declaratory order is appealable, those cases did not determine by whom such an order may be appealed.[34]

Accordingly, we respectfully decline to resolve whether AlohaCare had standing to appeal as an "interested person," and hold that AlohaCare had standing as a "person aggrieved."[35]

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[34] Similarly, the legislative history of HRS chapter 91, the Hawaiʻi Administrative Procedures Act (HAPA), indicates that one of the "basic purposes" of the HAPA was "[t]o provide for judicial review of agency decisions[.]" H. Stand. Comm. Rep. No. 8, in 1961 House Journal at 655. However, this broad statement of purpose does not clarify the legislature's intent with regard to standing, and does not evidence an intent to impose a lower standing threshold for appeals of declaratory orders than of orders in contested cases.

[35] We respectfully disagree with the dissent's assertion that we have "erect[ed] barriers to review the declaratory orders entered under HRS § 91-8" by declining to resolve this issue. Dissenting opinion at 4. To the contrary, we recognize that orders entered pursuant to HRS § 91-8 are appealable pursuant to HRS § 91-14, see Lingle, 107 Hawaiʻi at 183, 111 P.3d at 592, and hold that AlohaCare had standing to challenge the order at issue in the instant case.

We also respectfully disagree with the dissent's assertion that we have imposed a "new, substantive requirement" on appeals of HRS § 91-8 orders. Dissenting opinion at 41. The requirement that an administrative appeal be brought by a "person aggrieved" is set forth in HRS § 91-14. The cases cited by the dissent do not alter this requirement. See Lingle, 107 Hawaiʻi at 184-

(continued...)

B. Both accident and health insurers and HMOs are authorized to provide the closed panel plan required by the QExA contracts

In COL 16, the Insurance Commissioner identified a "substantial overlap between the powers granted to health maintenance organizations under HRS Chapter 432D and entities licensed under HRS [article] 431:10A." The Insurance Commissioner went on to state that a

> key distinction is that HMOs are the only licensed entities that may furnish health care directly to their members through facilities that it owns or operates and utilizing the services of physicians employed by the HMO and require that coverage is only provided when a member either utilizes its facilities and providers or is specifically authorized by its providers to utilize outside facilities or providers. An entity licensed as an HMO is not limited to furnishing care directly to its members through its owned facilities and employed providers, but it is authorized to do so. That authorization distinguishes entities licensed as HMOs from other risk-bearing entities licensed by the Insurance Commissioner in the State of Hawaii. Conversely, risk bearing entities licensed under HRS [article] 431:10A are prohibited from requiring that "service[s] be rendered by a particular hospital or person." HRS § 431:10A-205(b).

(Emphasis added).

AlohaCare argues that the two statutory provisions do not overlap and the Insurance Commissioner's interpretation of HRS 431:10A-205(b) "effectively [] repealed [the HMO Act] by administrative fiat."

As set forth below, HRS chapter 432D and HRS article 431:10A authorize both HMOs and accident and health insurers to provide the closed panel product envisioned by the QExA program.

[35](...continued)
86, 111 P.3d at 593-95; Vail, 75 Haw. at 47, 52-66, 856 P.2d at 1231, 1233-1240; Kim, 89 Hawaiʻi at 73, 75-76, 968 P.2d at 1084, 1086-87.

Moreover, this interpretation of the statutory schemes does not nullify the HMO Act.

1. The HMO Act and HRS article 431:10A authorize HMOs and accident and health insurers to provide closed panel products

This court must determine whether both HRS chapter 432D and HRS article 431:10A authorize the provision of health care services as required by the QExA contracts.[36] Initially, we note that the RFP appears to contemplate that both HMOs and accident and health insurers could provide the closed panel product required by the QExA RFP.[37] Nevertheless, the question for decision here is whether, under Hawaii's insurance code, accident and health insurers are authorized to provide that product.

There is no dispute that the HMO Act authorizes HMOs to provide or arrange for the services required under the QExA contracts. The plain language of HRS § 432D-1 indicates that HMOs are authorized to "provide or arrange for the delivery of

[36] As noted in COL 9, the QExA program also is "governed by federal law relating to the Medicaid program." No party disputes the Insurance Commissioner's finding that the "Social Security Act § 1903(m) and federal regulation at 42 C.F.R. § 438.116(b)(1) expressly state that a Medicaid managed care organization [] may be either a federally qualified HMO or 'be licensed or certified by [Hawaiʻi] as a risk bearing entity.'" Accordingly, we will not address federal law further.

[37] The RFP did not specifically require that an entity seeking to perform the QExA contract be licensed as an HMO, but stated that providing "health plans" must be "qualified and properly licensed[.]" The RFP also provided that "[t]he health plan shall be properly licensed as a health plan in the State of Hawaii (See Chapters 431, and 432, and 432D HRS)." The RFP defined "health plan" as "[a]ny healthcare organization, insurance company or health maintenance organization, which provides covered services on a risk basis to members in exchange for capitation payments." It thus appears that both "qualified and properly licensed" HMOs and insurers would be eligible to provide the QExA closed panel services under the terms of the RFP.

basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments, deductibles or both." "[B]asic health care services" are defined in HRS § 432D-1 as "preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory services, and diagnostic and therapeutic radiological services." Applying those definitions to the instant case, it is clear that properly licensed HMOs, like AlohaCare, are authorized pursuant to HRS § 432D-1 to "provide or arrange[,]" at their option, for the closed panel health care services required under the QExA program. Although the QExA RFP did not define "healthcare services[,]" the foregoing definitions appear to coincide with HMOs' authorization to provide or arrange for "preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory services, and diagnostic and therapeutic radiological services." See HRS § 432D-1. Therefore, HRS § 432D authorizes HMOs to provide or arrange for the closed panel services required under the QExA RFP.

The plain language of HRS § 431:10A-205(b), on the other hand, is not as clear as HRS chapter 432D regarding whether the statute authorizes accident and health insurers to offer the closed panel product required by the QExA contracts, because the statute prohibits a risk-bearing entity licensed as an accident and health insurer from requiring that medical services be rendered by "a particular hospital or person." The plain

language of HRS § 431:10A-205(b) is written in the singular, indicating that insurers may not require that services be rendered by a single "hospital or person." Accordingly, it appears that HRS § 431:10A-205(b) would allow accident and health insurers like United and Ohana to provide the QExA closed panel product because the RFP required that "enhanced quality healthcare services" be obtained from a network of providers and not a single "hospital or person." See HRS § 431:10A-205(b).

Nevertheless, the use of singular language is not determinative. Nobriga v. Raybestos-Manhattan, Inc., 67 Haw. 157, 163, 683 P.2d 389, 394 (1984) ("The use of words in a statute signifying the singular is . . . not conclusive."). HRS § 1-17 sets forth the general rule of statutory construction that "[w]ords . . . in the singular or plural number signify both the singular and plural number[.]" HRS § 1-17 (1993). This provision suggests that HRS § 431:10A-205(b) would not simply prohibit an accident and health insurer from requiring that services be rendered by "a particular hospital or person," but also by "particular hospitals or persons." If HRS § 431:10A-205(b) prohibits accident and health insurers from providing services by "particular hospitals or persons[,]" United and Ohana would not be able to provide the closed panel product required under the QExA contracts with their accident and health insurance licenses because the RFP required that services be rendered by a designated "provider network[.]"

This court has interpreted statutes using the statutory presumption in HRS § 1-17 only after reviewing the legislative history and context in which a statute was passed to determine whether the legislature intended to signify both the singular and plural forms of a word. See Nobriga, 67 Haw. at 163, 683 P.2d at 394 (looking to the legislative objective of HRS § 663-14 to determine that the legislature did not intend for there to be a different result based on whether the singular or plural form of the phrase "one joint tortfeasor" and the word "release" was used in the Uniform Contribution Among Joint Tortfeasors Act); see Wong v. Hawaiian Scenic Tours, Ltd., 64 Haw. 401, 403-05, 642 P.2d 930, 932-33 (1982) (per curiam) (reviewing the relevant legislative history and applying HRS § 1-17 to the term "person" to mean "persons" in a comparative negligence statute). Therefore, this court must look to legislative history to determine whether the legislature intended for HRS § 431:10A-205(b) to prohibit an accident and health insurer from requiring that services be rendered both by "a particular hospital or person," and also by "particular hospitals or persons."

The legislative history of HRS § 431:10A-205(b) is silent on whether accident and health insurers are prohibited from requiring that services be rendered by "particular hospitals or persons." See, e.g., S. Stand. Comm. Rep. No. 713, in 1955 Senate Journal, at 668. The legislative history also is silent regarding whether the statute precludes accident and health

insurers from offering a closed panel product, such as required by the QExA program. See id. Nevertheless, because of the historical context in which HRS § 431:10A-205(b) developed, it appears that the legislature did not intend to prohibit accident and health insurers from requiring that services be rendered by "particular hospitals or persons" when it adopted HRS § 431:10A-205(b). Although HRS § 431:10A-205(b) was enacted in 1987, the statute has remained virtually unchanged since 1955, when it was originally codified as Revised Laws of Hawaiʻi (RLH) § 181-55(b).[38] The text of HRS § 431:10A-205(b) also "substantially conforms" to a model law proposed by the National Association of Insurance Commissioners. See Digest of Bills Passed, 14th Legislature, Regular Session of 1987, p. 374-75. Closed panel plans, however, became popular only more recently and were unlikely to have been discussed in 1955, when the language of HRS § 431:10A-205(b) was first drafted. See, e.g., Nw. Med. Labs., Inc. v. Blue Cross and Blue Shield of Oregon, Inc., 794 P.2d 428, 432, n.2 (Or. 1990) (citation omitted)

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[38] RLH § 181-55(b) provided:

> Any group or blanket disability policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's option the insurer's obligation with respect to the amount so paid.

(Emphasis added).

(stating that in 1973, Congress enacted the federal HMO Act, 42 USC § 300(e), which specifically authorized "closed panel" HMOs).

Other jurisdictions have interpreted the phrase "particular hospital or person" in similar statutes to mean a single "hospital or person" and not "hospitals or persons[.]" In Insurance Commissioners v. Mutual Medical Insurance, Inc., 241 N.E.2d 56, 60-61 (Ind. 1968), superceded by statute on other grounds as held in Huffman v. Office of Envtl. Adjudication, 811 N.E.2d 806, 811-12 (Ind. 2004), the Indiana Supreme Court looked to the intent of the Indiana legislature when it required, "as a basic provision of individual and group accident and sickness policies, that 'the policy may not require that the service be rendered by a particular hospital or person[.]'" In that case, the "Appellant-Commissioner contend[ed] that this language reflects the legislative intent that no policy defeat an insured's right of recovery for medical services covered in the policy when the services are rendered by a person duly qualified in Indiana to perform them." Id. The case arose after insurers, under the applicable insurance laws of Indiana, allegedly did not compensate podiatrists for the performance of podiatry services because the podiatrists did not hold unlimited licenses to practice medicine in Indiana. Id. at 57-58. The Indiana Supreme Court held:

> It is our opinion that the language relied on by the appellants before the Commissioner is statutory language of differentiation, by which policy designs that would permit the insurer to direct the destiny of

> the cure through the specific designation of the person or facilities, are prohibited. The phrase 'may not require that the service be rendered by a particular hospital or person' distinguishes accident and sickness policy standards from the standards of the Workmens' Compensation Laws, which expressly permit and authorize an employer to select for the treatment of his employee, specific physicians, hospitals, nurses, or spiritual healers. Burns' Indiana Statutes, Anno., (1965 Repl.), s [sic] 40-1225. Therefore, Burns' ss [sic] 39-4253 and 39-4260 (supra) serve to prohibit this selective and discretionary designation of personnel for the treatment of the ill, rather than to affirmatively require insurers to indemnify for all attempted cures which are legally rendered.

Id. at 61 (emphasis added).

The same statutory language also was at issue in Herring v. American Bankers Insurance Co., 216 So. 2d 137 (La. App. 1969). In Herring, the Court of Appeal of Louisiana considered whether an insurance policy provision that benefits would be paid for confinement only in hospitals recognized by any of three medical associations violated a Louisiana statute providing that such insurance policies may not require that services be rendered by "a particular hospital or person." Id. at 138-39. The Court of Appeal held:

> We do not construe the provision requiring treatment by a hospital recognized by at least one of the associations named in the policy as naming a particular hospital. The statute is not intended to prevent a provision in a policy requiring an institution to meet certain standards before it may be classed as a hospital within the meaning of the policy. We believe that the intent of the statute in prohibiting the naming of a particular hospital has reference to the specification in the policy that an insured must go to a certain hospital designated in the contract by its trade name. We do not believe that the statute intended to prohibit a contract containing a provision prescribing a quality or status which an institution must possess before it will be included under the definition of an acceptable hospital within the terms of the policy. The statute, we feel, was intended to prevent any practice of

> favoritism between an insurance company and some particular hospital or institution. This is not the situation in the case under consideration.

Id. at 140 (emphasis added).

Similar to the provision at issue in Herring, the QExA RFP did not require that QExA members go to a "particular hospital or person" to receive health care. Instead, the QExA RFP required that members receive services in the QExA network, and if medically necessary covered services were not available in the network or on the island of residence, that the member be provided services out-of-network or transported to another island to access the services. The analyses in Mutual Medical Insurance and Herring support the conclusion that HRS § 431:10A-205(b) only applies to a single "particular hospital or person," and that the statute should be read without resorting to HRS § 1-17.

Moreover, prohibiting accident and health insurers from requiring that services be rendered by particular "hospitals or persons" would be inconsistent with the ability of those insurers to offer "managed care plan[s,]" as recognized under HRS § 432E-1.[39] HRS § 432E-1 was enacted in 1998 – 43 years after the

[39] The Patients' Bill of Rights Act, HRS § 432E-1, defines a "[m]anaged care plan" as:

> any plan, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a health insurance issuer, a fiscal intermediary, a payor, a prepaid health care plan, and any other mixed model, that provides for the financing

(continued...)

"particular hospital or person" provision in HRS § 431:10A-205(b) was first codified – and recognized that authorized insurers may provide "for the financing or delivery of health care services or benefits to enrollees through . . . [a]rrangements with selected providers or provider networks to furnish health care services or benefits." Prohibiting accident and health insurers from requiring that services be rendered by particular "hospitals or persons" would conflict with the recognition of authority in HRS § 432E-1, thereby repealing a portion of the later-enacted statute. See G. ex rel K. v. State Dep't of Human Servs., 676 F. Supp. 2d 1046, 1081 (D. Haw. 2009).[40]

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[39](...continued)

> or delivery of health care services or benefits to enrollees through:
>
> > (1) Arrangements with selected providers or provider networks to furnish health care services or benefits; and
> >
> > (2) Financial incentives for enrollees to use participating providers and procedures provided by a plan;
>
> provided, that for the purposes of this chapter, an employee benefit plan shall not be deemed a managed care plan with respect to any provision of this chapter or to any requirement or rule imposed or permitted by this chapter which is superseded or preempted by federal law.

HRS § 432E-1. (Emphasis added).

[40] The district court in G. ex rel K. addressed the same facts at issue in the instant case and also found that HRS § 431:10A-205(b) should not be read in light of HRS § 1-17 because "such a construction would be inconsistent with the legislative intent expressed in a later-enacted statute, HRS § 432E-1." 676 F. Supp. 2d at 1081, n.24. Although the decisions of federal courts on matters of state law are not dispositive, they can be persuasive. Cf. Arquero v. Hilton Hawaiian Joint Venture LLC, 104 Hawaiʻi 423, 429-30, 91 P.3d 505, 511-12 (2004) (stating that the federal courts' interpretation of Title VII of the Civil Rights Act of 1964 is "persuasive, but not controlling" when interpreting analogous Hawaiʻi state laws).

Such a result would violate two rules of statutory construction. First, "[t]he general rule is that repeals by implication are not favored and that if effect can reasonably be given to two statutes, it is proper to presume that the earlier statute is to remain in force and that the later statute did not repeal it." State v. Pacariem, 67 Haw. 46, 47, 677 P.2d 463, 465 (1984) (quoting State v. Gustafson, 54 Haw. 519, 521, 511 P.2d 161, 162 (1973) (per curiam)); see also Richardson v. City & Cnty. of Honolulu, 76 Hawaiʻi 46, 55, 868 P.2d 1193, 1202 (1994) (quoting Mahiai v. Suwa, 69 Haw. 349, 356-57, 742 P.2d 359, 366 (1987))(stating that "where there is a 'plainly irreconcilable' conflict between a general and a specific statute concerning the same subject matter, the specific will be favored. However, where the statutes simply overlap in their application, effect will be given to both if possible, as repeal by implication is disfavored[]"). Second, "[l]aws in pari materia, or upon the same subject matter, shall be construed with reference to each other. What is clear in one statute may be called upon in aid to explain what is doubtful in another." HRS § 1-16 (1993). Here, it is possible to give effect to HRS § 431:10A-205(b) and HRS § 432E-1 by reading the former statute in the singular, thereby avoiding repeal by implication.

Accordingly, both HMOs and accident and health insurers are authorized to arrange for medical services for members using a defined network of providers, i.e., particular "hospitals or

persons." HRS § 432D-1; HRS § 431:1-201(a). We note, however, that only an HMO is authorized to arrange for services to be rendered by a single "hospital or person." In addition, an HMO, unlike an accident and health insurer, may "provide" "for the delivery of basic health care services" in facilities it owns or operates utilizing the services of physicians employed by the HMO. See HRS § 432D-1.

Based on the foregoing, HRS article 431:10A and chapter 432D authorize accident and health insurers and HMOs, as risk-bearing entities, to provide the closed panel product required by the QExA contracts.

2. Allowing accident and health insurers to provide closed panel products does not nullify the HMO Act

AlohaCare contends that, by allowing accident and health insurers to provide a closed panel product, the Decision authorized these insurers to "operate an HMO" in violation of HRS chapter 432D. AlohaCare presents two arguments in support of its position: 1) the HMO Act unambiguously provides that no person[41] shall operate a health maintenance organization without a license, and providing services pursuant to the QExA contracts requires an HMO license; and 2) the legislature intended for the HMO Act to occupy the "'field' of activities to which the [HMO]

[41] For the purposes of HRS chapter 432D, "[p]erson" is defined as "any natural or artificial person including by not limited to individuals, partnerships, associations, trusts, or corporations." HRS § 432D-1.

Act applie[s] (and for which it require[s] a license)" thereby prohibiting other risk-bearing entities from engaging in activities authorized by HRS chapter 432D. For the reasons set forth below, AlohaCare's arguments are meritless.

a. The HMO Act is ambiguous and cannot be construed literally without repealing HRS § 432E-1

AlohaCare contends that the Insurance Commissioner improperly departed from the broad, literal meaning of the phrase "operate a health maintenance organization" in HRS § 432D-2(a). HRS § 432D-2(a) provides, in pertinent part: "No person shall establish or operate a health maintenance organization in this State without obtaining a certificate of authority under this chapter." HRS § 432D-2(a) (emphasis added).

AlohaCare contends that the words "shall"[42] and "operate" in HRS § 432D-2(a) are not ambiguous and indicate that the HMO Act preempts the field of activities to which the HMO Act applies. Moreover, even if the terms are ambiguous, AlohaCare contends that the "proper course of action is to look to a dictionary to determine the ordinary meaning[s,]" which confirm that the HMO Act preempts the field of activities to which it applies.

[42] No party disputes that the term "shall" in HRS § 432D-2(a) is mandatory, as opposed to discretionary. See Clark v. Arakaki, 118 Hawaiʻi 355, 370, 191 P.3d 176, 191 (2008) (defining the word "shall" according to Blacks's Law Dictionary as mandatory); Blacks's Law Dictionary 1499 (9th ed. 2009) (defining the word "shall" as "[h]as a duty to; more broadly, is required to . . . . This is the mandatory sense that drafters typically intend and that courts typically uphold[]"). Accordingly, we will not address this argument further.

As set forth below, the language of HRS § 432D-2(a) is not clear and unambiguous. Moreover, a literal interpretation would have the effect of repealing a portion of HRS § 432E-1, which was enacted three years after the HMO Act.

The HMO Act does not define the word "operate" or what it means to "operate a health maintenance organization[.]" See HRS § 432D-1. An HMO, however, is defined pursuant to HRS § 432D-1 as "any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments, deductibles, or both." (Emphasis added).

It is true that "when a term is not statutorily defined, this court may resort to legal or other well accepted dictionaries as one way to determine its ordinary meaning." Estate of Roxas v. Marcos, 121 Hawaiʻi 59, 66, 214 P.3d 598, 605 (2009) (internal quotation marks and citation omitted). "Operate" is defined in the sixth edition of Black's Law Dictionary as "[t]o perform a function, or operation, or produce an effect." Black's Law Dictionary 1091 (6th ed. 1990).[43] Webster's Third New International Dictionary similarly defines "operate," as it relates to an entity, as "to manage and put or keep in operation whether with personal effort or not[.]" Webster's Third New International Dictionary 1581 (1966). If this court defined

[43] The ninth, and most recent, edition of Black's Law Dictionary does not define "operate." The word "operate" also is not defined in the seventh or eighth editions.

"operate" for purposes of HRS § 432D-2(a) according to the dictionaries above, as AlohaCare requests, any "provi[sion] or arrange[ment] for the delivery of basic health care services[]" would require a "certificate of authority under [HRS chapter 432D]."

However, this broad definition conflicts with the conclusion that accident and health insurers, pursuant to HRS article 431:10A, may provide a closed panel product like the one required by the QExA contracts pursuant to their insurance licenses. AlohaCare's proffered definition also conflicts with the plain text of HRS § 432E-1, which recognizes that "managed care plan[s]" (like the one required by the QExA RFP) can be offered or administered by several types of risk-bearing entities licensed by the Insurance Division, including both HMOs licensed under HRS chapter 432D and insurers governed by HRS article 431:10A. See HRS § 432E-1. Therefore, if AlohaCare's definition of "operat[ing] a health maintenance organization" is correct, the definition would nullify the portion of HRS § 432E-1 that recognizes that risk-bearing entities other than HMOs are authorized to offer or administer managed care plans.

In the instant case, the Insurance Commissioner properly gave effect to all three relevant statutory schemes, and thereby avoided possible repeal by implication, by defining "operate a health maintenance organization" in HRS § 432D-2(a) as "engaging in activities which only an HMO is authorized to do."

See Pacariem, 67 Haw. at 47, 677 P.2d at 465 (noting that repeals by implication are disfavored). Under this definition, accident and health insurers licensed pursuant to HRS article 431:10A may still offer managed care plans as recognized in HRS § 432E-1. Accordingly, it is not appropriate to define the word "operate" in HRS § 432D-2(a) in the way suggested by AlohaCare, because to do so would be to ignore the interplay among HRS chapters 432D, 432E and article 431:10A, and would nullify a portion of HRS § 432E-1.

This definition does not nullify the HMO Act – or strip AlohaCare of its HMO license – because HMOs may still "provide or arrange for the delivery of basic health care services" in accordance with HRS § 432D-1. Instead, this definition focuses on a distinguishing feature of HMOs – their authorization to provide or furnish health care directly to their members through facilities they own or operate and utilizing the services of physicians employed by the HMO. See HRS §§ 432D-1 and 432D-3(a)(3); see also G. ex rel K., 676 F. Supp. 2d at 1081, n.24.[44]

b. Legislative history indicates that the HMO Act was not enacted to preempt the field of managed care regulation

In support of its position that the Decision nullifies the HMO Act, AlohaCare contends that the legislature intended for the HMO Act to occupy the field of activities to which the HMO

[44] HRS § 432D-3(a)(3) provides that HMOs may "[furnish] health care services through providers, provider associations, or agents for providers which are under contract with or employed by the [HMO.]"

Act applies, thereby disallowing other risk-bearing entities to engage in activities authorized by HRS chapter 432D. AlohaCare contends that "the legislature was clear in its desire to regulate HMOs because they were not being regulated by any law even though a number were already in business."

However, AlohaCare misstates the applicable legislative history, which conversely indicates that the HMO Act was not enacted to preempt the field to which it applies. Prior to the HMO Act's enactment in 1995, HMOs were, in fact, regulated by the Department of Labor and Industrial Relations and were not unregulated entities. See H. Stand. Comm. Rep. No. 168, in 1995 House Journal, at 1091. Thus, contrary to AlohaCare's assertion, the legislative history does not indicate that the act was passed to "fill a regulatory void." See H. Stand. Comm. Rep. No. 168, in 1995 House Journal, at 1091. Instead, the legislative history repeatedly reveals that the HMO Act was passed in order to monitor the financial soundness of HMOs.[45] See S. Stand. Comm.

[45] Accordingly, AlohaCare's reliance on Gardens at West Maui Vacation Club v. County of Maui, 90 Hawaiʻi 334, 340-41, 978 P.2d 772, 778-79 (1999), for the proposition that the HMO Act "should be given full effect" because the HMO Act was intended to cover the field is misplaced. In Gardens at West Maui, this court found that constitutional provisions and legislative acts covered the whole subject of property taxation power and embraced the entire law in that regard thereby repealing another statute by implication. Id. In making its determination, this court relied on the text of the constitutional amendment that "expressly and manifestly [was] designed to transfer to the counties broad powers of real property taxation" and the proceedings of the 1978 constitutional convention, in which it was explicitly noted that "[the] Committee changed this amendment to include the phrase . . . in order to clarify the standing committee's intent to grant all taxing powers relating to real property to the counties, except Kalawao. . . . Your Committee rejected an amendment to return this section to its original language which rests all taxing powers with the State." Id. at 341, 978 P.2d at 779. In the instant (continued...)

Rep. No. 1283, in 1995 Senate Journal, at 1309 (stating that "HMOs in Hawaii are not regulated or monitored on a continuing basis for financial soundness[;]" "this bill will provide for the prudent financial regulation of HMOs that is needed in Hawaii[;]" and that "[t]he purpose of this bill is to provide for the financial regulation of [HMOs] in [Hawaiʻi]") (emphasis added); H. Stand. Comm. Rep. No. 418, in 1995 House Journal, at 1181 (stating that "the purpose of this bill is to authorize the regulation of the financial soundness of [HMOS]") (emphasis added); S. Stand. Comm. Rep. No. 884, in 1995 Senate Journal, at 1161 (stating that "[s]upporters [of the bill] were interested in guarding against insolvencies in these organizations and protecting the consumers enrolled in these plans from losses[]") (emphasis added); H. Stand. Comm. Rep. No. 168, in 1995 House Journal, at 1091 (stating that "[t]he purpose of this bill is to regulate [HMOs], including the establishment of minimum financial requirements to ensure the stability of these entities[]") (emphasis added).

The underlying purpose of regulating the financial soundness of HMOs is further clarified when it is considered that prior to 1995, health insurance companies and mutual benefit societies, like Hawaiʻi Medical Services Association, were routinely monitored for financial soundness by the Insurance

[45](...continued)
case, unlike in Gardens at West Maui, neither the text of the HMO Act nor the legislative history reveal an intent to cover the whole field.

Division of the DCCA, but HMOs were not. See H. Stand. Comm. Rep. No. 168, in House Journal, at 1091.

Because the HMO Act does not cover the field of managed care regulation, and because the relevant statutes can be read together and there is no explicit language or policy reason not to give each statute effect, we do not read the HMO Act as repealing HRS chapter 432E by implication. Cf. Gardens at West Maui, 90 Hawaiʻi at 340-41, 978 P.2d at 778-79 (finding that constitutional provisions and legislative acts covered the whole subject of property taxation power and embraced the entire law in that regard thereby repealing another statute by implication); see also Gustafson, 54 Haw. at 520, 511 P.2d at 162 (reading two statutes together recognizing the rule of statutory interpretation avoiding implied amendment or repeal, and holding that a later-enacted statute did not repeal by implication an earlier-enacted statute because there was an "absence of any clear countervailing policy reason to disregard our maxims of statutory construction").

C. AlohaCare's argument that United and Ohana are "performing their QExA contracts under no licensing authority" is without merit

AlohaCare's argument that United and Ohana are "performing their QExA contracts under no licensing authority" is rooted in COL 4. COL 4 provides:

> The QExA contracts entered into by DHS with [Ohana] and [United] are not contracts of insurance. HRS § 431:1-201(a) provides that "[i]nsurance is a contract whereby one undertakes to indemnify another

> or pay a specified amount upon determinable contingencies." Accordingly, determining the validity of the QExA contracts is not the business of insurance and is outside the jurisdiction of the Commissioner. Except for relief in the form of a declaration that neither [United] nor [Ohana] are properly licensed to perform the services required under the QExA contract, all other claims for relief based upon allegations of the Petition regarding the validity of the contracts entered into by DHS with [Ohana] and [United] are denied as beyond the jurisdiction of the authority. HAR § 16-201-50(l)(C).

(Emphasis added).

AlohaCare's contention is based on a multi-step argument. AlohaCare appears to assert that because the Insurance Commissioner concluded that the QExA contracts entered into by DHS with United and Ohana are not contracts of insurance, the services required to be provided by the contracts are not insurance. AlohaCare then appears to contend that because the services under the contracts are not insurance, United and Ohana's insurance licenses pursuant to HRS article 431:10A do not authorize them to perform the services. Therefore, AlohaCare contends that United and Ohana are performing the QExA contracts "under no licensing authority." AlohaCare asserts that the only entity that may perform the services is an HMO, because any "activities" performed by HMOs are, by definition, not insurance.

AlohaCare's interpretation of COL 4 is incorrect. Although the relationship between DHS and the QExA plans is not insurance, the relationship between United and Ohana and their respective QExA members does involve the provision of insurance. See G. ex rel K., 676 F. Supp. 2d at 1081-82. AlohaCare has not

appealed the factual bases underlying COL 4, namely that United and Ohana have agreed to operate a managed care program that provides health care services to QExA members – not DHS – according to the terms of the RFP and as set out by the Insurance Commissioner in his FOFs. Because AlohaCare did not challenge any findings of fact on appeal, the findings of fact are binding on this court. See ʻŌlelo: The Corp. for Cmnty. Television v. Office of Info. Practices, 116 Hawaiʻi 337, 348-49; 173 P.3d 484, 495-96 (2007) ("Findings of fact . . . that are not challenged on appeal are binding on the appellate court.") (quoting Okada Trucking Co., Ltd. v. Bd. of Water Supply, 97 Hawaiʻi 450, 458, 40 P.3d 73, 81 (2002)). When the uncontested requirements of the QExA RFP are read alongside the text of HRS § 431:1-201(a),[46] defining the term "insurance," it is clear that United and Ohana have agreed to assume a risk based on a relationship with QExA members – not DHS – and are "undertak[ing] to indemnify another or pay a specified amount upon determinable contingencies." See HRS § 431:1-201(a). DHS merely aids in the provision of insurance through the QExA contract. Or, stated differently: "The risk that the companies bear is associated with the coverage they provide to their enrollees - insurance coverage. The State DHS facilitates that insurance by contracting with the plans and paying them for the risks they assume." G. ex rel K., 676 F.

[46] HRS § 431:1-201(a) (2005) provides that "[i]nsurance is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies."

Supp. 2d at 1082.

Accordingly, AlohaCare's argument that United and Ohana are "performing their QExA contracts under no licensing authority" is wrong. United and Ohana hold insurance licenses pursuant to HRS article 431:10A and were contracted to provide insurance services for QExA members.

IV. CONCLUSION

For the foregoing reasons, we affirm the December 28, 2009 judgment of the circuit court.

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